STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4529SNF	A. BUILDING: _____ B. WING _____	01/30/2015

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LAS VENTANAS RETIREMENT COMM SNF	10401 WEST CHARLESTON BLVD LAS VEGAS, NV 89135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This statement of Deficiencies was generated as a result of a State Licensure survey completed (in conjunction with a federal recertification survey) from 1/27/15 through 1/30/15, in accordance with Nevada Administrative Code (NAC) Chapter 449, Skilled Nursing Facilities. The current census at the time of the survey was 57. The sample size was 15 residents. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state of local laws. The following regulatory deficiencies were identified:	Z 000		
Z342 SS=D	NAC 449.74511 Personnel Records - Licenses, TB, Background 3. A current and accurate personnel record for each employee of the facility must be maintained at the facility. The record must include, without limitation: a) Evidence that the employee has obtained any license, certificate or registration, and possesses the experience and qualifications, required for the position held by the employee; b) Such health records as are required by chapter 441A of NAC which include evidence that the employee has had a skin test for tuberculosis in accordance with NAC 441A.375; and c) Documentation that the facility has not received any information that the employee has	Z342		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

02/27/15

6899 5C7V11

If continuation sheet 1 of 3

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Z342	Continued From page 1 been convicted of a crime listed in paragraph (a) of subsection 1 of NRS 449.188. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 14 employees met the requirements of NAC 441A.375 concerning tuberculosis (TB) (Employee #1 and #3). Findings include: NAC441A.375: "3. Before initial employment, a person employed in a medical facility, a facility for the dependent, a home for individual residential care or an outpatient facility shall have a: (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter..." Employee #1 was hired on 12/11/14. Review of employee's file revealed an Immunization Record documenting PPD (purified protein derivative) was administered on 1/14/2013, 1/21/2013 and 5/19/2014. The document failed to provide evidence of the dates the TB skin tests was read and any results of the three tests.	Z342		

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Z342	Continued From page 2 Employee #3 was hired on 11/4/14. Review of employee's file revealed a facility's Tuberculin Test form which documented a TB test had been given on 8/25/14 and read on 8/27/14. Results of the test were checked as negative, with no documentation of the measurement of redness or induration. On 2/20/14, the Administrator confirmed the aforementioned missing TB skin tests. Severity: 2 Scope: 1	Z342		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare recertification survey conducted at your facility from 1/27/15 through 1/30/15, in accordance with 42 Code of Federal Regulations (CFR) Chapter IV, Part 483 - Requirements for Long Term Care Facilities. The census on the first day of the survey was 57. The sample size was 15 residents. One complaint was investigated during the survey. Complaint # NV000413777- The complaint could not be substantiated. Allegation #1: Admission, Transfer & Discharge Rights: Medication not prescribed upon discharge. The investigation for the allegation of medications not being prescribed included: - Review of the resident of concern's medical record which included copies of prescriptions written by the physician for discharge to an assisted living facility. - Interview was conducted with the Director of Nursing. - Review of Policy and Procedure titled, "Discharging the Resident", revised date December 2012. The findings and conclusions of any investigation by the Division of Public and Behavioral Health	F 000		

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F 000	Continued From page 1 shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to maintain an accurate record of the resident's daily output for 2 of 15 sampled residents with a catheter (Resident #1 and #10). Findings Include: Resident #1 Resident #1 was admitted to the facility on 12/9/14, with diagnosis including failure to thrive, unspecified retention of urine, dehydration, generalized pain and malnutrition of a moderate degree.	F 315		

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On 1/27/15 at 8:30 AM, Resident #1 was observed moving towards her room from the nurses station. A catheter bag was observed attached to her wheelchair.

A review of Resident #1's order summary report order date 12/14/14, documented "Foley catheter care q (every) shift every 12 hours".

A review of Resident #1's medical record lacked documented evidence of an intake and output record.

A review of Resident #1's Progress Notes from 12/9/14 - 1/27/15, lacked consistent documentation of urine output.

Resident #10

Resident #10 was admitted to the facility on 1/8/15 and re-admitted on 1/26/15, with diagnosis including generalized pain, hypertension, atrial fibrillation, malignant neoplasm prostate and congestive heart failure.

On 1/27/15 at 8:50 AM, Resident #10 was observed in his room conducting therapy with his catheter bag attached to his wheelchair.

A review of Resident #10's order summary report order date 1/1/15, documented "Foley catheter care q shift two times a day for foley care."

A review of the Resident #10's Progress Notes from 12/19/14 - 1/30/15, lacked consistent documentation of urine output.

The facility's policy entitled Catheter Care,

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F 315	Continued From page 3 Urinary, revised October 2010, documented the following under input/output "Maintain an accurate record of the resident's daily output, per facility policy and procedure. The facility's policy entitled Output, Measuring and Recording, revised October 2010, documented "the purpose of this procedure is to accurately determine the amount of urine that a resident excess in a 24-hour period." The policy further documented "record the amount noted on the output side of the intake and output record." On 1/30/15 at 9:50 AM, the Director of Nursing (DON) verbalized nurses were expected to document how much urine was excreted by a resident every shift in the progress notes in the resident's chart. The Director of Nursing reviewed the progress notes for Resident #1 and Resident #10 and confirmed the documentation did not follow facility policy and did not meet facility expectations.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were not stored at the bedside for 1 of 15	F 323		

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Continued From page 4 sampled residents (Resident #2) and 3 unsampled residents (Resident #20, #21 and #22).

Findings include:

On 1/27/15 at 8:10 AM during the initial tour, a container of anti-fungal powder was on Resident #2's bedside table.

On 1/27/15 at 8:11 AM, Resident #2 explained the anti-fungal powder was administered by staff to her stomach and sometimes under her breasts.

On 1/27/15 at 8:50 AM, a Register Nurse (RN) verbalized the medication should not be at the bedside. It should be on the treatment cart and the nurses were to administer the medication.

On 1/28/15 in the afternoon, a Licensed Practical Nurse (LPN) verbalized the resident did not have a physician order for the anti-fungal powder. The clinical record lacked documented evidence the resident had been assessed to self administer the anti-fungal cream and a care plan for self administration of medication had been developed. The LPN explained the policy for medications at the bedside required a physician order, a self administration assessment must be performed and the medication must be care planned.

On 1/27/15 at 8:25 AM, three bottles of hydrating cleanser 4 ounces (oz) were on a dresser in Resident #20's room.

On 1/27/15 at 8:52 AM, an RN verbalized the hydrating cleanser should not be in the residents room. It should be on the treatment cart.

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F 323	Continued From page 5 On 1/29/15 at 11:28 AM, Arnicare cream 2.6 oz was on a tray table in Resident #21's room. The resident explained a family member would apply the cream on her hands. On 1/29/15 at 11:30 AM, a Licensed Nurse (LN) verbalized the resident did not have a physician's order for the Arnicare cream. The clinical record lacked documented evidence the resident had been assessed to self administer the Arnicare cream and a care plan for self administration of medication had been developed. On 1/27/15 at 10:40 AM, Castor Oil was stored at bedside in Resident #22's room. On 1/27/15 at 10:40 AM, the Director of Nursing (DON) indicated there should be an order for the castor oil. On 1/30/15 at 9:55 AM, the DON indicated an order was obtained for Resident #22's caster oil, administer as needed. The DON verbalized the medication was moved to the medication cart. Review of the Self Administration of Medication policy revised 12/12, documented in part: "The staff and the physician will assess each resident's mental and physical abilities and determine whether a resident was able to self-administer medications. The staff and the physician will document their findings and the choices of residents who may be able to self administer medications. Medications which are self administered must be stored in a safe and secure place, which was not accessible by other residents. Staff shall identify and give the Charge	F 323		

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F 323	Continued From page 6 Nurse any medications found at a resident's bedside."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff followed the weight loss policy related to reweighing the resident after a 5% weight loss/gain for 2 of 15 sampled residents. (Resident #5 and #8). Findings include: Resident #8: Resident #8 was originally admitted to the facility on 4/14/14 with diagnosis including dysphagia, esophageal reflux, transient ischemic attack, cerebral infarction without residual deficits and secondary Parkinsonism. Resident #8's Weights and Vitals Summary from 4/16/14 through 1/27/15, revealed significant	F 325		

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weight loss/gain on the following dates:

- 8/27/14 - 180.3 pounds (lbs)
- 9/01/14 - 169.0 lbs(sitting scale) (a loss of 6.26%)
- 10/1/14 - 175.4 lbs
- 11/13/14 - 189 lbs (a gain of 7.19%)
- 11/25/14 - 200 lbs
- 12/1/14 - 184.5 lbs (a loss of 8.25%)
- 12/16/14 - 188.3 lbs
- 12/22/14 - 175.1 lbs (a loss of 7.01%)

The medical record lacked documentation the resident was rewieghed per facility policy.

Resident #8's Nutritional Screening and Assessment assessment dated 11/30/14, indicated the following: Swallowing difficulty, dysphagia as exhibited by mechanical soft ground texture diet, monitor weight and follow diet as ordered.

Resident #8's Care Plan initiated on 4/26/14, revised on 1/22/15, documented as follows: - Resident #8 was at risk for inadequate oral intake, history of dysphagia, edema and significant weight changes.
- Resident #8 will maintain adequate nutritional status as evidenced by maintaining weight within 165-175, free from significant changes, target date 3/26/15.

On 1/28/15 at 1:20 PM, the Licensed Practical Nurse (LPN) indicated a resident was always re-weighed if there was a 5 lb fluctuation in weight regardless of the time frame. The LPN verbalized a resident was re-weighed at the time of admission, and for the following four weeks, and monthly after that.

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On 1/28/15 at 1:20 PM, the LPN indicated on 11/13/14 and 9/11/14, Resident #8 should have been re-weighed within 24 hours.

On 1/29/15 at 1:35 PM, the RD verbalized residents weights were reviewed weekly. The RD explained the staff provided notification of resident's weight loss/gain, however there was no formal documentation of communication.

On 1/29/15 at 2:09 PM, the RD verbalized in November, 2014, the weight scales needed to be calibrated and repaired. The RD indicated the type of scale used to weigh residents varied, and weights were not taken accurately prior to November, 2014.

On 1/30/15 at 9:40 AM, the Registered Nurse (RN) indicated if a resident had weight loss and there was no new orders, the nurses verbally communicated with the Registered Dietician (RD). The RN verbalized weight loss was documented in the health status and weekly assessment after verbally notifying the RD. The RN indicated there was no documentation of the verbal communication with the RD, however the nurses could print out a dietary consult form and turn it in to the RD; if a dietary consult was not turned in there was no other method to alert the RD.

Resident #5

Resident #5 was admitted to the facility on 4/2/14, with diagnosis including malnutrition, hypertension, pain, debility, history of falls and anxiety disorder.

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Resident #5's care plan documented "resident has potential nutritional problem, at risk for inadequate oral intake, small appetite, history of significant weight loss". The goal documented resident "will maintain adequate nutritional status as evidenced by maintaining weight within 115-125 pounds and free from significant changes".

Resident #5's Weights and Vitals Summary from 4/3/14 - 1/25/15, revealed significant weight loss/gain on the following dates:

- 6/9/14 - 127 pounds (lbs) (sitting scale)
- 6/30/14 - 116 lbs (sitting scale) (a loss of 8.66%)
- 7/1/14 -116 lbs - re-weight (sitting scale)
- 7/14/14 - 125 lbs (sitting scale) (a gain of 7.76%)
- 7/18/14 - 109.9 lbs (wheelchair) (a loss of 12.08%)
- 8/11/14 - 110.5 lbs (sitting scale)
- 8/25/14 - 119 lbs (wheelchair) (a gain of 7.69%)

The resident's chart lacked documented evidence the resident was re-weighed and the dietician was notified per facility policy.

On 1/29/15 at 8:35 AM, the LPN indicated a resident was to be re-weighed if there was more than a 5 lb fluctuation in weight. The LPN confirmed a re-weight was not conducted for Resident #5 for three instances of weight loss or gain. The LPN confirmed the medical record lacked documented evidence the dietician, physician or family members were notified of the change.

On 1/29/15 at 1:35 PM, the Registered Dietician

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F 325	Continued From page 10 (RD) verbalized nursing staff should notify her if a resident has a change in weight of 5% or more. The RD verbalized she was not always notified in writing of the change. The RD confirmed the weight loss noted in the medical record for Resident #5 was over 5% and she should have been notified. The RD was unable to provide documentation of notification of the resident's change in weight. On 1/30/15 at 9:50 AM, the Director of Nursing (DON) verbalized nursing staff was not communicating weight loss in writing to the dietician. The DON was unaware the policy contained direction to notify the Dietician in writing. The facility's policy entitled Weight Assessment and Intervention, revised April, 2012, documented the following: "Any weight change of 5% or more since the last weight assessment, is retaken the next day for confirmation. If the weight was verified, nursing immediately notified the Dietician in writing. Verbal notification was confirmed in writing. The Dietician responded within 24 hours of receipt of written notification."	F 325		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility: 1) failed to ensure oxygen tubing and humidifier bottles were dated for 4 unsampled residents (Resident #16, #17, #18, and #19); 2) failed to ensure linens were properly stored; 3) failed to ensure resident care equipment was disinfected between residents for 1 of 15 sampled residents (Resident #2) and 2 unsampled residents (Residents # 23 and #24) and 4) failed to ensure

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facility policy for catheter tubing was followed for 1 of 15 sampled residents (Resident #1).

Findings include:

1. On 1/27/15 at 9:00 AM, the following observations were made on the initial tour:

The tubing attached to a nebulizer in Resident #16's room was not dated.

On 1/27/15 9:20 AM, a Certified Nursing Assistant (CNA) verified there was no date on the nebulizer tubing in the Resident #16's room.

Resident #17's room contained an oxygen concentrator with oxygen tubing and a humidifier bottle attached to the concentrator. The oxygen tubing and humidifier bottle were not dated.

On 1/27/15 in the morning, a CNA verified there was no date on the oxygen tubing for the nebulizer or humidifier in Resident #17's room.

Resident #18's room contained an oxygen concentrator with oxygen tubing attached to the concentrator. The oxygen tubing was not dated.

On 1/27/15 in the morning, a CNA verified the oxygen concentrator tubing in Resident #18's room was not dated.

Resident #19's room contained an oxygen concentrator with oxygen tubing and a oxygen mask attached to the concentrator. The oxygen tubing and mask were not dated.

On 1/27/15 in the morning, a CNA verified there was no date on the oxygen concentrator tubing

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mask in Resident #19's room.

On 1/28/15 at 2:45 PM, the Infection Control Nurse explained the oxygen tubing was changed every Saturday. The Infection Control Nurse revealed if the tubing was not changed, bacteria would grow in the tubing.

2. On 1/27/15 at 8:17 AM, a pillow case was on top of the linen cart outside of resident room #105.

On 1/27/15 at 8:25 AM, linens were tucked in the hand rail outside of resident room #110.

On 1/27/15 at 8:25 AM, a Registered Nurse(RN) verified the linens were to be stored in the linen cart.

3. On 1/28/15 at 7:20 AM, a Licensed Practical Nurse (LPN) (Employee #1) was observed utilizing a rolling, automated vital sign monitor to obtain temperature, pulse and blood pressure for Resident #23. The LPN failed to disinfect the blood pressure cuff or the monitor upon completion of task.

On 1/28/15 at 8:00 AM, the LPN utilized the same vital sign machine to obtain vital signs for Resident #24. Prior to and upon completion of obtaining Resident #24's vital signs, the LPN failed to disinfect the blood pressure cuff or the monitor.

On 1/28/15 at 8:50 AM, an LPN (Employee #6) was observed utilizing a hand-held vital sign monitor to obtain blood pressure and pulse for Resident # 2. The LPN laid the vital sign monitor on the resident's bed upon approaching the resident. Upon completion of task, the LPN

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Continued From page 14 returned the vital sign monitor to the medication cart without disinfecting the monitor or cuff.

On 1/28/15 at 9:20 AM, Employee #6 acknowledged the vital sign monitor was on the resident's bed and was not disinfected after use. The LPN indicated, it (the vital sign monitor) should be cleaned between residents.

On 1/30/15 at 8:50 AM, the Infection Control Nurse revealed the expectation is for all care equipment to be cleaned between resident use. The Infection Control nurse indicated sani-wipes should be located on the medication carts and on the rolling vital sign monitors to be used for disinfecting.

On 1/30/15 at 9:15 AM, Employee #1 acknowledged the rolling vital sign monitor had been utilized between residents without cleaning. The LPN indicated sani-wipes were available on the unit and should have been used.

Review of facility policy entitled, "Cleaning and Disinfection of Resident-Care Items and Equipment", revised date of October 2009 documented in part, "Reusable items are cleaned and disinfected or sterilized between residents."

4. Resident #1 was was admitted to the facility on 12/9/14, with diagnosis including failure to thrive, unspecified retention of urine, dehydration, generalized pain and malnutrition of a moderate degree.

A review of the facility's policy entitled Catheter Care, Urinary revised October, 2010, documented under the infection control section in part: "Be sure the catheter tubing and drainage

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F 441	Continued From page 15 bag are kept off the floor." On 1/27/15 at 8:30 AM, Resident #1 was observed moving towards her room from the nurses station. A catheter bag was observed attached to her wheelchair, and the catheter tubing was observed dragging on the ground. On 1/27/15 at 8:40 AM, the Licensed Practical Nurse (LPN) confirmed the observation of Resident #1's catheter tubing dragging along the ground. The LPN verbalized this was inappropriate as this was an infection control issue.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure water temperatures in 16 out of 60 resident rooms throughout the facility were maintained at a safe level. Findings include: On 1/29/15 at 8:30 AM, water temperatures in random resident room showers throughout the facility were checked. A certified nursing assitant and licensed practical nurse were present in four resident rooms and confirmed temperatures.	F 465		

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The temperatures were as follows:
- Room 106 - 123 degrees F (Fahrenheit)
- Room 110 - 125
- Room 111 - 125
- Room 113 - 131
- Room 114 - 125
- Room 115 - 130
- Room 121 - 129
- Room 124 - 135
- Room 129 - 134
- Room 203 - 128
- Room 204 - 127
- Room 206 - 123
- Room 214 - 124
- Room 220 - 130
- Room 222 - 131
- Room 229 - 128

On 1/29/15 at 9:30 AM, the Director of Maintenance explained the water temperatures were monitored weekly on Mondays. The Director of Maintenance revealed there was one boiler for the building. The Director of Maintenance verbalized the water temperatures in residents' rooms should be no higher than 120 degrees Fahrenheit.

A review of the temperature monitoring log revealed shower temperatures during the past year were consistently less than 120 degrees Fahrenheit.

On 1/29/15 at 9:41 AM, temperatures were obtained in several resident shower areas with the Director of Maintenance and Administrator present to confirm the findings.

On 1/29/15 at 10:23 AM, the Director of Maintenance indicated the maintenance staff had

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F 465	Continued From page 17 turned up the boiler temperature without notifying the Director of the action.The maintenance staff had turned the boiler up 4 degrees. The facility did not have a policy regarding boiler temperature checks and/or monitoring. The Director of Maintenance acknowledged the temperature of the water had not been monitored after a change was made to the boiler and explained that standard practice would include checking the temperature after changes were made to the boiler system. On 1/29/15 at 12:50 PM, the Director of Maintenance provided a list of current shower temperatures, all readings obtained were less than 103 degrees.	F 465		